AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS LABORATORY ACCREDITATION BOARD (ASCLD/LAB)

ANNUAL ACCREDITATION AUDIT REPORT FROM <u>August 5, 2010</u> to August 5, 2011

Indicate the period of activity above. The period should include a full year from accreditation anniversary to the next anniversary. The Annual Report is due on or within 60 days after the laboratory's anniversary date.

Accreditation Certificate Number (Submit a separate form for each certificate number): 324					
Laboratory Name: Austin Police Department					
Agency Name: Austin Police Department					
LABORATORY DIRECTOR: Check if changed since the last report Name: William Gibbens Title: Forensic Division Manager					
Street / Mailing Address: 812 Springdale Road/PO BOX 689001					
City: Austin State/Province: TX Zip/Postal Code: 78768-9001					
Country: USA Telephone: 512-974-5118 Fax: 512-974-6640					
E-mail: bill.gibbens@ci.austin.tx.us					
NAME OF SYSTEM DIRECTOR (if applicable):					
QUALITY MANAGER: Check if changed since the last report					
Name: Anthony Arnold Title: Quality Assurance Manager					
Telephone: 512-974-5103 Fax: 512-974-6640					
E-mail: _tony.arnold@ci.austin.tx.us					
LABORATORY DELEGATE (Check one)					
 ☑ The Laboratory Director listed above is the Delegate. ☑ As Laboratory Director, I have named the following individual as the Delegate for this laboratory: 					
Name: Title:					
Telephone: Fax:					

SELF-EVALUATION OF COMPLIANCE

Using standards and criteria in the most current Accreditation Manual, a self-evaluation of your laboratory operations should form the basis for completing the following table.

	Total Number Possible	Total Yes	Total No	Total N/A	Percentage Yes
Essential	91	63	11	17	85
Important	45	38	5	2	88
Desirable	16	16	0	0	100

While the current manual should always be used for annual audits, laboratories which were accredited under the standards and criteria of an earlier version of the manual are not required to be in compliance with new standards which were added or raised to essential after their accreditation. However, laboratories must include a statement concerning such standards, which they do not meet, to indicate the steps that are being taken to move toward compliance with those standards and criteria.

PERSO	ONNEL						
Total nu	Total number of employees subject to proficiency testing (including vacancies):54						
accurately number s	The total number of employees subject to proficiency testing (including vacancies) is an important number and should be accurately determined. This is the number used to calculate your laboratory's shares for the annual administrative fee. The number should not include administrative or clerical personnel. The number does include all laboratory positions subject to proficiency testing, whether in training, providing technical support or currently vacant.						
IMPO	ORTANT If the response to any of the following is YES, please attack	an explanation					
Durin	ng the past year:						
•	Did the annual audit reveal any instance of substantive non-compliance with any <i>Essential</i> criteria?	🛚 Yes 🗌 No					
The primary purpose of the <i>Annual Accreditation Audit Report</i> is to document that the laboratory has made at least an annual determination that operations continue to be in compliance with accreditation standards, with a particular focus on <i>Essential</i> criteria. Laboratories must report <i>substantive</i> occurrences of non-compliance with essential criteria. "Substantive" means potentially having a significant bearing on the quality of the work of the laboratory, even if for a short period of time. With the expectation that a laboratory will always react internally and appropriately to instances of known non-compliance, it is not necessary to report every isolated occurrence of non-compliance. For deciding upon inclusion in this report, factors such as significance, substance and time-span of non-compliance should be evaluated. When in doubt, include the finding in your report.							
•	Was any discipline or sub-discipline added, reinstated, or suspended?	Yes No					
	List the discipline(s), action(s) taken and date:						
•	Did an inconsistency or error on a proficiency test occur that required corrective action to be implemented?	🛚 Yes 🗌 No					
•	Did an inconsistency or error on casework occur that required corrective action to be implemented?	🛚 Yes 🗌 No					
IMPO	ORTANT If the response to the following is NO, please attach an exp	lanation					
•	Did the laboratory meet the external proficiency testing requirements of each discipline, including the submission of all test results by the test provider's deadline?	🛚 Yes 🗌 No					
SIGNA	TURE (A typed name should be inserted for reports submitted via E-mail) 07-20-	2011					
007	Laboratory Director Date	e					
INSTR	CUCTIONS						
•	or mailed to:	SCLD/LAB 9 J Technology Drive arner, NC 27529					
•	Questions about the completion of the <i>Annual Accreditation Audit Report</i> may be a ASCLD/LAB at 919-773-2600 or mcreasy@ascld-lab.org	ddressed to					
Every la	boratory must submit an <i>Annual Accreditation Audit Report</i> to ASCLD/LAB on any date of the laboratory's accreditation. This report and supporting documentation with (1.4.2.3). Laboratories applying for accreditation must conduct an audit in order.	can serve as proof of an					

This report must include explanations of any essential criteria scored "No" during the self-

Every laboratory must submit an *Annual Accreditation Audit Report* to ASCLD/LAB on or within 60 days of the anniversary date of the laboratory's accreditation. This report and supporting documentation can serve as proof of an annual audit (1.4.2.3). Laboratories applying for accreditation must conduct an audit in order to complete the Grade Computation Sheets and other supporting documents required with the application. Those documents may serve as proof of an audit for the purpose of the accreditation inspection. Laboratories having an inspection for renewal of accreditation, may utilize the application documents and inspection report as supporting documentation of an audit

evaluation.

for the year in which the inspection is conducted. While appropriate as supporting documentation, neither the application for renewal, nor the subsequent inspection report replaces the required *Annual Accreditation Audit Report*.



Austin Police Department Field Support Services Forensic Science Division

TO: Bill Gibbens, Division Manager

FROM: Tony Arnold, Quality Assurance Manager

DATE: July 20, 2011

SUBJECT: 2011 Annual Internal Audit

The Austin Police Department Forensic Science Division conducted its annual internal ASCLD/LAB accreditation audit and FBI DNA Audit during the month of June 2011. The ASCLD/LAB audit was conducted by T. Arnold, E. Morris, E. Pusch, J. Cormier, K. Sanchez, R. Salazar, I. Farrell, S. Siegel, K. Frierson and G. Karim. The FBI DNA Audit was conducted by C. Carradine.

The audit consisted of examining the lab utilizing the criteria described in the 2008 ASCLD/LAB Legacy Program accreditation guidelines as well as the FBI DNA audit document. The Laboratory was found to be non-compliant to the following standards. The standards, the specific issue and the remediation to take place are listed below.

Standard: 1.1.2.6 (E) Do clear written and well understood procedures exist for control

of materials and supplies.

Section: Chemistry

Issue: The section SOPs require that drug standards are secured with controlled access to

the supervisor and designee. Although there is a lock box inside the laboratory freezer designated for drug standard storage, a few new drug standards are stored

in the laboratory freezer outside the locked box.

Remediation: Chemist who was using these standards for validation was counseled on proper

storage of drug standards. Vials were weighed; no discrepancy in weights was

noted.

Conclusion: Remediation accepted.

Section: Crime Scene

Issue: As per SOP 6.4.2.03, a cell phone call log book is to exist for use of

departmental cell phones utilized by Crime Scene Specialists. No

such log was located or known to exist.

Remediation: It was determined that this log is no longer required. The CS SOPs have been

updated to eliminate this requirement.



Standard: 1.2.2.3 (I) Is there sufficient delegation of authority?

Section: Crime Scene

Issue: Section SOPs state that in the event of the absence of the Assistant Manager, a

designated Crime Scene Supervisor will be responsible for acting as the Assistant

Manager. This practice has is not occurring.

Remediation: The CS SOPs have been updated to eliminate this requirement.

Conclusion: Remediation accepted.

Standard: 1.2.2.6 (I) Are performance expectations established and are they understood

by laboratory personnel?

Section: Crime Scene

Issue: The section SOPs state that the assistant manager is responsible for completing

performance reviews for Crime Scene Section; however, these are done by the CS

supervisors.

Remediation: The CS SOPs have been updated to correctly relocate this duty from the Assistant

Manager to the Crime Scene Supervisors.

Conclusion: Remediation accepted.

Standard: 1.4.1.1 (E) Does the laboratory have a written or secure electronic chain of

custody record with all necessary data which provides for complete tracking

of all evidence?

Section: Crime Scene

Issue: The section SOPs (CS P.102) require the use of an evidence transfer form when

transferring evidence directly between APD personnel prior to submission to the Evidence Control Section. However, through interview, it was determined that evidence is routinely transferred between sections electronically, without the use

of the evidence transfer form.

Remediation: The applicable section of the CS SOPs has been updated to clarify that this form

is required when transferring evidence to personnel outside the Forensic Science

Division.

Conclusion: Remediation accepted.

Standard: 1.4.1.3 (E) Is evidence stored under proper seal?

Section: Chemistry

Issue: a. The clandestine lab storage room in the laboratory contains items that are not

sealed. (blue plastic jugs, plastic bag) or not labeled for identification. These items may be items stored pending destruction, but no labeling is in place.

Remediation: a. All items have been properly sealed and marked for identification. Chemicals

awaiting destruction have been properly marked, segregated and relocated to

external storage.

Standard: 1.4.2.6 (E) Are new technical procedures scientifically validated before being

used in casework and is the validation documentation available for review?

Section: Chemistry

Issue: The BZP Validation conducted in August 2010, had corrections made to the

method, but there is no date on the corrections. It is unknown if these changes

were made before or after the validation was approved.

Remediation: Changes to this method were determined to be administrative and did not impact

the quality of the results produced. This method has been discontinued pending a

new validation.

Conclusion: Remediation accepted.

Standard: 1.4.2.10 (E) Does the laboratory routinely check the reliability of its

reagents?

Section: Chemistry

Issue: a. No log book was located for reagents in the north vent hood.

b. Reagents were not tested monthly as prescribed by the section SOPs. Several

reagent logs were missing QC checks:

K. Sanchez – June 2010 C. Kiyak – July 2010

R. Salazar – May & July 2010

G. Harbison – June & August 2010

Remediation: a. Regents in north vent hood were left over from Spot Test Training class that

was conducted on 5-19-2011 and left in hood when class was completed. They

were not used for case work. They have been disposed.

b. These reagents were quality checked and found to be acceptable the month before and the month after the missing month. These spot test reagent are of

preliminary value and are not used for determination of conclusive results no case

work will require reanalysis.

Conclusion: Remediation accepted.

Standard: 1.4.2.13 (E) Are the instruments/equipment properly calibrated?

Section: Chemistry Laboratory
Issue: a. The 1000uL pipette fa

a. The 1000uL pipette failed calibration, but was signed off as acceptable. Additionally, the section SOP states that pipettes will be checked using known standards, but the method fails to specify what standards are used.

b. The FTIR (SN ending 1592) performance verification log: $\frac{1}{2}$

a. The June 27, 2008 ValPro report was printed and placed in binder for the 2/28/11 check. This document show "fail" yet was approved as acceptable.

b. The ValPro report performed on January 30, 2011 shows a date stamp of June 2, 1010

c. The section SOP requires that laboratory standard weights should be checked after the annual re-certification of the balance. No logbook was located for this function.

d. One balance (30408405) is out of service, but no signage has been placed on the balance to prevent usage.

Remediation: a. This pipette was used by only one analyst. Since calibration failure was at the lower range of the 1000ul pipette and since it passed at the range for which it was intended to be used, 1000ul, there was no impact on the quality of the results.



This pipette, as well as the 10 ul and 100 ul pipettes have not been used for casework since 2-2-2010 when the failure was noted for the 1000ul. We currently use a different process for the dilution of samples for quantitation that went into effect in 10-02-09. These pipettes have been marked as "Not for use for casework" and will only be used for training purposes.

b. The ValPro report for February 28, 2011 and January 30, 2011 were located in instrument's electronic folder, printed and placed in the maintenance log. They indicated that the instrument passed verification. This was a clerical error and had no impact on the performance or quality of data from this instrument.

c. The laboratory standard weights were checked on 2-29-11 and determined to be accurate. The documentation was placed in the Stock Reagent Log. Two brass weights were taken out of circulation due to unknown manufacturer and traceability.

Conclusion: Remediation accepted.

Standard: 1.4.2.16 (E) Are conclusions and opinions in reports supported by data

available in the case record, and are the examination documents sufficiently detailed such that, in the absence of the examiner(s), another competent examiner or supervisor could evaluate what was done and interpret the

data?

Section: Chemistry

Issue: The instrumental methods for GC/MS are not controlled. As a result, another

examiner cannot specifically determine the parameters used for the identification.

Remediation: Methods have been locked down and a new method development protocol is

being written. All old methods will be archived for historical research for each

instrument.

Conclusion: Remediation accepted.

Standard: 1.4.2.24 (E) Does the laboratory monitor the testimony of each examiner at

least annually and is the examiner given feedback from the evaluation?

Section: Firearms, Crime Scene and Chemistry

Issue: No court monitoring documentations were located for D. Justice, S. Shults or G.

Harbison pertaining to testimony during the 2010 evaluation period.

Remediation: Crime Scene: Employee S. Shults did not testify for the year 2010. A

memorandum was prepared and placed in her Audit Notebook.

Firearms: D. Justice did not testify in the year 2010. A memorandum was

prepared and placed in his Audit Notebook.

Chemistry: A testimony monitoring form was completed by the federal

prosecutor for Glenn's 2010 testimony.



Standard: 1.4.3.4 (I) Does the laboratory conduct proficiency testing using re-

examination or blind techniques?

Section: Division

Issue: Re-examination or blind testing is not practiced within the Division.

Remedy: No action necessary

Conclusion: The laboratory is not in compliance with this criterion for 2010.

Standard: 2.6.1 (I) Does each examiner possess a baccalaureate degree with

science courses?

Section: Firearms

Issue: Not all examiners within the Firearms Section possess a baccalaureate degree.

Remedy: No action necessary

Conclusion: The laboratory is not in compliance with this criterion for 2010.

Standard: 2.8.1 (I) Does each examiner possess a baccalaureate degree with

science courses?

Section: Latent Prints

Issue: Not all examiners possess a baccalaureate degree.

Remedy: No action necessary

Conclusion: The laboratory is not in compliance with this criterion for 2010.

Standard: 2.8.5 (E) Did each examiner successfully complete an annual proficiency test?

Section: Latent Prints

Issue: No latent print proficiency test documents were located for J. Pena for 2010.

Remediation: No casework was performed by J. Pena in 2010. An external latent print

proficiency has been purchased for 2011.

Conclusion: The laboratory is not in compliance with this criterion for 2010. There was

no impact to the quality program since this examiner completed no

casework.

Standard: 2.10.1 (E) Do examiners meet the requirements of their job descriptions?

Section: Crime Scene

Issue: In the section SOPs, the duties of the Assistant Manager include "Conduct

technical work performed by the Crime Scene Section when necessary". The current proficiency status of the assistant manager precludes performance of

crime scene technical work.

Remediation: This information was listed as a duty of the Assistant Manager. This entire

segment of the procedure has been removed from the Crime Scene Section SOP's.

Conclusion: Remediation accepted.

Section: Firearms

Issue: The Statement of Qualifications for G. Karim lists crime scene as a discipline, but

has not successfully completed crime scene proficiency.

Remediation: G. Karim is not assigned to the crime scene section. The Statement of

Qualifications for G. Karim has been updated listing only the Firearms/Toolmarks

disciplines.



Standard: 3.3.1 (E) Is access to the operational area of the laboratory controllable and

limited?

Section: Crime Scene

Issue: Per SOP 3.3.14, all non-CSU Section personnel are to sign the log book when

entering the S. Congress vehicle processing location. Interviews indicate that the firearms examiner has authorized access to the building, but is not considered

crime scene personnel and has not signed the entrance log.

Remediation: The CS SOPs have been updated to include access by all authorized personnel.

All others will sign the entrance log.



Austin Police Department Technical Support Bureau Forensic Science Division

To: ASCLD/LAB From: Tony Arnold

Quality Assurance Manager

Date: July 20, 2011

Re: 2010 Proficiency Test Inconsistency Report

Two 2010 proficiency exams were deemed unacceptable:

✓ The external proficiency exam, CTS 10-560 (bloodstain pattern analysis), completed by B. Gibbens was determined to contain a class II error. Remediation was performed and accepted by the Proficiency Review Committee.

The internal proficiency exam, CTS 10-560 (bloodstain pattern analysis), completed by J. Pena was determined to contain a class I error. This analyst was removed from blood pattern analysis casework. Subsequent internal remediation was completed and accepted.

Austin Police Department Corrective Action Reports Class I and II

Class	LabNo	CAR Incident Date	Issue	Date Completed by QA	Action
Olabo	Labito	Crare mondone Bato	10000	by Q/	
II	L1000034	010210	Incorrect preliminary results	1/18/2011	Employee counseled. Drug section process changed to eliminate release of preliminary analysis information.
			Issuance of draft report without admin		Employee counseled. No incorrect information released. No corrected report
II	L1101188	012811	review. Employed unvalidated method	02/10/2011	issued. Method validated. Method used is acceptable in the field. No adverse impact
II	L1003652	040110	in casework. Erroneous exclusion of latent print,	4/20/2010	to evidence.
II	LP	08-16-2010	discovered during tech review. Marihuana exhibits not marked while in drying room,	7/13/2011	Error discovered prior to issuance of report. No impact on quality.
II	L1016376	12/30/2010	excluded from case. Unsecured evidence		Written reprimand
II	L1101288	02-11-2011	after hours. Issuance of draft report without admin	2/16/2011	Verbal reprimand
II	L1102809	03/28/2011	review.	3/30/2011	No impact on case quality. No impact to case quality, error corrected
	L1009033	04/07/2011	Mislabeled evidence admin review with no tech review on	5/19/2011	while in process.
II	L1103755	04/15/2011	required case.		
II	L1105431	05/11/11	Evidence left in van DNA contamination	5/23/2011	Evidence examined, no obvious impact to quality.
II	L0911469	042710	of evidence. Item packaged with other evidence, does not match	5/5/2010	Employee counseled.
II	L1004721	051711	description. Class II inconsistency, print elimination-	2/8/2011	Employee counseled. No impact to quality.
II	L1006220	060310	incomplete exemplars.	9/6/2010	Employees counseled
II	L1007286	061510	Print from intern identified at scene.	8/20/2010	Employee counseled.
II	L0910259	062510	DNA contamination of evidence.	7/2/2010	Employee counseled.
II	L1006657	071510	Class II exclusion. Intern fingerprint in	8/2/2010	Employee counseled.
II	L107286	081310	scene Class II	10/27/2010	Employee counseled.
II	L1008234	081710	inconsistency, print elimination	10/25/2010	Error detected during review, not reported.

Austin Police Department Corrective Action Reports Class I and II

			Class II		
		004040	inconsistency, print	10/05/0010	
II	L1008947	081910	elimination	10/25/2010	Analyst removed from casework
			Class II		
	1.4040445	000040	inconsistency, print	40/40/0040	Evolution of the last
II	L1010445	090210	elimination	10/13/2010	Employee counseled.
			sop violation, did not		Tune verified working along no impact to
	L1010609	091610	perform tune evaluation.	9/20/2010	Tune verified, working okay, no impact to case work.
II	L1010609	091610	DNA contamination	9/20/2010	case work.
II	L0913192	092509	of evidence.	4/21/2010	No action required.
"	20913192	092309	Unescorted visitors in	4/21/2010	No action required.
П	L1013129	110310	lab area.	11/30/2010	Employee counseled
"	21013123	110010	Corrected report	11/30/2010	Employee counscied
			issued without		
Ш	L1011092	110410	supervisor approval.	11/4/2010	Employees counseled
			Fingerprint of M.	, .,	
			Gibson identified on		
			latent lifts from		
П	L1006845	110410	casework.	11/23/2010	Employee counseled.
			Initiated FA analysis		
			prior to fingerprint		
II	L1015272	110611	work.	1/7/2011	Employee counseled.
					Employee received documented
			CS tech mislabeled		performance counseling and future cases
II	L1009033	050111	swab box	5/19/2011	will be checked for accuracy.
			Electronic data not		
			attached to case.		
			Case was admin		
			reviewed by analyst		
П	L1012349	10062010	without supporting data.	2/16/2011	Verbal reprimand
11	L1012348	10002010	uaia.	2/10/2011	verbai reprimanu